



Esthetics Skillbook

CONFIDENTIAL PATIENT INFORMATION

Date _____

Name _____ Date of Birth _____

Address _____

Email Address _____

Daytime Phone _____ Work Phone _____ Cell Phone _____

Your Occupation _____

Dermatologist _____ Phone _____ / Physician _____ Phone _____

Emergency Contact _____ Phone _____

Referred by Friend ☐ Newspaper Advertisement ☐ Mailer or Insert ☐ Other _____

Yes ☐ No ☐ Is this your first facial? Yes ☐ No ☐ body treatment? Yes ☐ No ☐ massage?

If not, when was your last facial _____ body treatment _____ massage _____?

What is the reason for your visit today? _____

What special concerns do you have? _____

Yes ☐ No ☐ Are you currently under a physician's care for any skin conditions?

If so, what condition specifically and for how long: _____

Yes ☐ No ☐ Have you had a recent operation? If so, please describe _____

Yes ☐ No ☐ Were any medications prescribed?

Yes ☐ No ☐ Are you still on medication?

Yes ☐ No ☐ If so, what kind? _____ What is the dosage? _____

Yes ☐ No ☐ Is the area of the operation still sensitive to different temperatures or amounts of pressure?

What is the date of your last gynecological visit? _____ Pap smear? Yes ☐ No ☐

Breast exam? Yes ☐ No ☐ Mammogram? Yes ☐ No ☐ Menstrual cycle? Yes ☐ No ☐

Yes ☐ No ☐ Are you pregnant? If so, how far along? _____ Are you (will you be) nursing? Yes ☐ No ☐

Yes ☐ No ☐ Are you taking birth control? If so, what kind and for how long? _____

Yes ☐ No ☐ Have you seen any changes in your skin since you started using it?

If you have, what changes have you seen? _____

Yes ☐ No ☐ Are you on hormone replacement therapy?

If so how has your skin adjusted to it? _____

Yes ☐ No ☐ Have you had any problems with moisture loss/becoming drier in any areas?

Date of last dental exam ____/____/____

Yes ☐ No ☐ Were dental x-rays required?

- Yes ☐ No ☐ Do you wear contact lenses?
- Yes ☐ No ☐ Do you smoke? If so, how much and how often? _____
 Do you normally smoke inside ☐ or outside ☐?
 If you DO NOT smoke, are you around smoke while at home ☐ or in the workplace ☐?
 If yes, how often are you around it? _____
- Yes ☐ No ☐ Do you have difficulty managing stress?
- Yes ☐ No ☐ Do you or have you had cancer?
 If so, what type and where? _____
 When was it discovered? _____
 When was your last treatment? _____
 What kind of treatment was it? _____
- Yes ☐ No ☐ Has anyone in your family ever been diagnosed with cancer?
 If so, how are they related to you? _____
 Are you using (or used): Azelex ☐ Differin ☐ Renova ☐ Retin-A ☐ Tazarac ☐ Accutane ☐
 Glycolic or Alphahydroxy Acids ☐ If so, how long? _____
 What are you using it for? _____
- Yes ☐ No ☐ Have you noticed a difference? If so, what? _____
- Yes ☐ No ☐ Do you have any concerns with the use of this product? If so, what? _____
- Yes ☐ No ☐ Do you have acne or experience frequent blemishes? How frequently? _____
- Yes ☐ No ☐ Do you have any allergies? If so please list: _____
- Yes ☐ No ☐ Are you taking allergy medications? If so please list: _____
- Yes ☐ No ☐ Are you taking any medications not listed above? If so, please list: _____
 What products do you presently use for face & body? Soap ☐ Cleanser ☐ Toner ☐ Scrub ☐
 Moisturizer ☐ Mask ☐ Sunscreen ☐ Other: _____
 What brand/line are these products? _____
 How do these products seem to be working for you? _____
 How often do you use these products? _____
 What is the SPF in any sunscreens you may be using? _____
 Do you take: Fish Oil ☐ Flax Seed ☐ Multivitamin ☐ Energy-Enhancing Supplement ☐
 If so, what kind and how often? _____
- Yes ☐ No ☐ Have you noticed a difference in anything? _____
 Daily water consumption? None ☐ 1-4 glasses ☐ 5-8 glasses ☐ More than 8 ☐
 Daily caffeine consumption? None ☐ 1-2 cups of coffee ☐ 1-2 cans of soda ☐ ...or more ☐
 How often do you exercise? Never ☐ daily ☐ 2-3 times a week ☐ weekends only ☐

Please check if you are affected by or are currently experiencing any of the following:

- | | | | |
|---|---|---|---|
| Anemia ☐ | Cortisone treatments ☐ | High blood pressure ☐ | Respiratory disease ☐ |
| Arthritis ☐ | Diabetes ☐ | Immune Disorders ☐ | Shortness of breath ☐ |
| Asthma ☐ | DVT or Phlebitis ☐ | Jaw pain ☐ | Sinus problems ☐ |
| Back problems ☐ | Eating Disorder ☐ | Kidney disease ☐ | Skin diseases ☐ |
| Bleeding gums ☐ | Eczema ☐ | Liver disease ☐ | Skin rash ☐ |
| Blood disorders ☐ | Epilepsy ☐ | Lupus ☐ | Swelling of feet or ankles ☐ |
| Broken Bones ☐ | Fever blisters ☐ | Metal pins or plates ☐ | Thyroid problems: |
| Bruise Easily ☐ | Headaches ☐ | Nervous problems ☐ | Hyperthyroid ☐ |
| Cardiac problems ☐ | Hemophilia ☐ | Numbness ☐ | Hypothyroid ☐ |
| Chemotherapy ☐ | Hepatitis ☐ | Pacemaker ☐ | Ulcer ☐ |
| Circulatory problems ☐ | Herpes ☐ | Psychological problems ☐ | Urinary/kidney problems ☐ |
| Claustrophobia ☐ | HIV/AIDS ☐ | Radiation treatments ☐ | Varicose Veins ☐ |

Please explain any of the above, including treatments or any significant others not mentioned: _____

Please check any known allergies:

Aspirin ☐ Barbiturates ☐ Codeine ☐ Iodine ☐ Local anesthesia ☐ Penicillin ☐ Sulfur ☐ Other ☐ _____

I understand that the services offered are not a substitute for medical care and any information provided by the esthetician is for educational purposes only and not diagnostically prescriptive in nature. I further understand that the information herein is to aid the esthetician in giving the most appropriate and safe treatment available and remains confidential.

Client Signature _____ Date _____

Consent to administer treatment for Minor/Dependent: Parent/Guardian _____ Date _____

Esthetician: _____ Makeup Artist: _____ Massage Therapist: _____

Hair Removal Technician: _____ Client comfort level: Sensitive ☐ Hot ☐ Cold ☐



Esthetics Skillbook



Patient Name: _____ Follow Up Appointment: _____

MORNINGS (AM)

1. CLEANSER: *to remove product, dirt, oil, makeup.*

Dampen hands and apply product in upward and outward circular motion from the chin up. For men, upward and outward from the beard line above, downward and outward from the beard line below.

2. TONER: *to balance ph.*

3. MEDICATION: *to correct skin conditions within the epidermis.*

4. SERUM: *to stimulate within the deeper layers of the epidermis (stratum spinosum, stratum basale and mucosom).*

5. MOISTURIZER: *hydrates the upper layers of the epidermis (stratum corneum, stratum lucidum and stratum granulosum)*

Face _____

Eye _____

Lip _____

6. SUNBLOCK: *Apply 20 to 30 minutes before going outside.*

7. MAKEUP

How To Apply:

Liquid: spray

Pad: dab, wipe upward

Brush: upwards movement

Serum: palm, sandwich, dab

Cream: neck to forehead

Powder: towards hairgrowth

Manual Exfoliate: upward circular motion

Chemical Exfoliate: apply for one minute, then rinse.

Amounts:

Liquid: One drop

Cream: Pea size

Pump: 1 to 2 pumps

EVENINGS (PM)

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Face _____

Eye _____

Lip _____

7. MASK: *specific treatment for the epidermis.*

8. TARGET AREA:



Esthetics Skillbook

FACE AND BODY ASSESSMENT FOR HAIR REMOVAL

Date _____

Name _____

Skin Type Normal ☐ Dry ☐ Oily ☐ Combination ☐

Skin Texture Thin ☐ Medium ☐ Thick ☐

Thickness of Hair Lowest ☐ Low ☐ Medium ☐ High ☐ Highest ☐

Tweeze between Visits Every Day ☐ Every Other Day ☐ 3 times a week ☐ Once a week ☐ Less than once a week ☐

Length of Hair Lowest ☐ Low ☐ Medium ☐ High ☐ Highest ☐

Texture of Hair

Cheek Area Lowest ☐ Low ☐ Medium ☐ High ☐ Highest ☐

Chin Area Lowest ☐ Low ☐ Medium ☐ High ☐ Highest ☐

Forehead Lowest ☐ Low ☐ Medium ☐ High ☐ Highest ☐

Entire Face Lowest ☐ Low ☐ Medium ☐ High ☐ Highest ☐

Brows Lowest ☐ Low ☐ Medium ☐ High ☐ Highest ☐

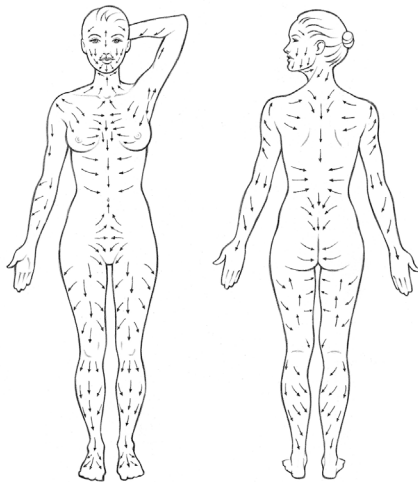
Bikini Lowest ☐ Low ☐ Medium ☐ High ☐ Highest ☐

Leg Lowest ☐ Low ☐ Medium ☐ High ☐ Highest ☐

Underarm Lowest ☐ Low ☐ Medium ☐ High ☐ Highest ☐

Arms Lowest ☐ Low ☐ Medium ☐ High ☐ Highest ☐

Head Lowest ☐ Low ☐ Medium ☐ High ☐ Highest ☐



Shape of Eyes Round ☐ Close Set ☐ Protruding ☐ Heavy Lidded ☐ Dark Circles ☐ Small ☐ Deep Set ☐

Direction of hair Growth

Face

Body

Method of Hair Removal Waxing (hard or soft) ☐ Blading/Razoring ☐ Threading ☐ Electrology ☐ IPL ☐
Tweezing ☐ Sugaring ☐ Other ☐ _____

Lesions Moles ☐ Erythema ☐ Comedone ☐ Milia ☐ Spider Veins ☐
Telangiectasia ☐ Warts ☐ Other ☐ _____

Other Diseases/Disorders Dehydrated Skin ☐ Keratosis/Keratoses ☐ Irritation ☐ Erosion ☐ Melanoma ☐ Sun Damage ☐
Seborrhea ☐ Rosacea ☐ Scar ☐ Enlarged Pores ☐ Couperous Skin ☐ Asphyxiated ☐ Ulcer ☐
Hyperkeratinization ☐ Sensitivities ☐ Adult Acne ☐ Atrophy ☐ Other ☐ _____

Do you have a history of Circulatory Disorders ☐ Lupus/DLE ☐ Diabetes ☐ Eczema ☐ Epilepsy ☐ Seborrhea ☐ Herpes ☐
Hemophilia ☐ Dermatitis ☐ Psoriasis ☐ Pregnancy ☐

Are you using Azelex ☐ Differin ☐ Renova ☐ Retin-A ☐ Tazarac ☐ Accutane ☐ AHA/Glycolic Acid ☐

Undergoing Skin Treatments No ☐ Yes ☐ _____

Skin Disorders ☐ Lack of skin sensation Location: _____
☐ Sunburn Location: _____
☐ Scar Tissue Location: _____
☐ Mole(s) Location: _____
☐ Fracture(s)/Sprain(s) Location: _____
☐ Varicose Veins Location: _____
☐ Prescription medication(s) Location: _____

Pain Scale Very sensitive ☐ Sensitive ☐ Medium ☐ High tolerance ☐ Highest tolerance ☐

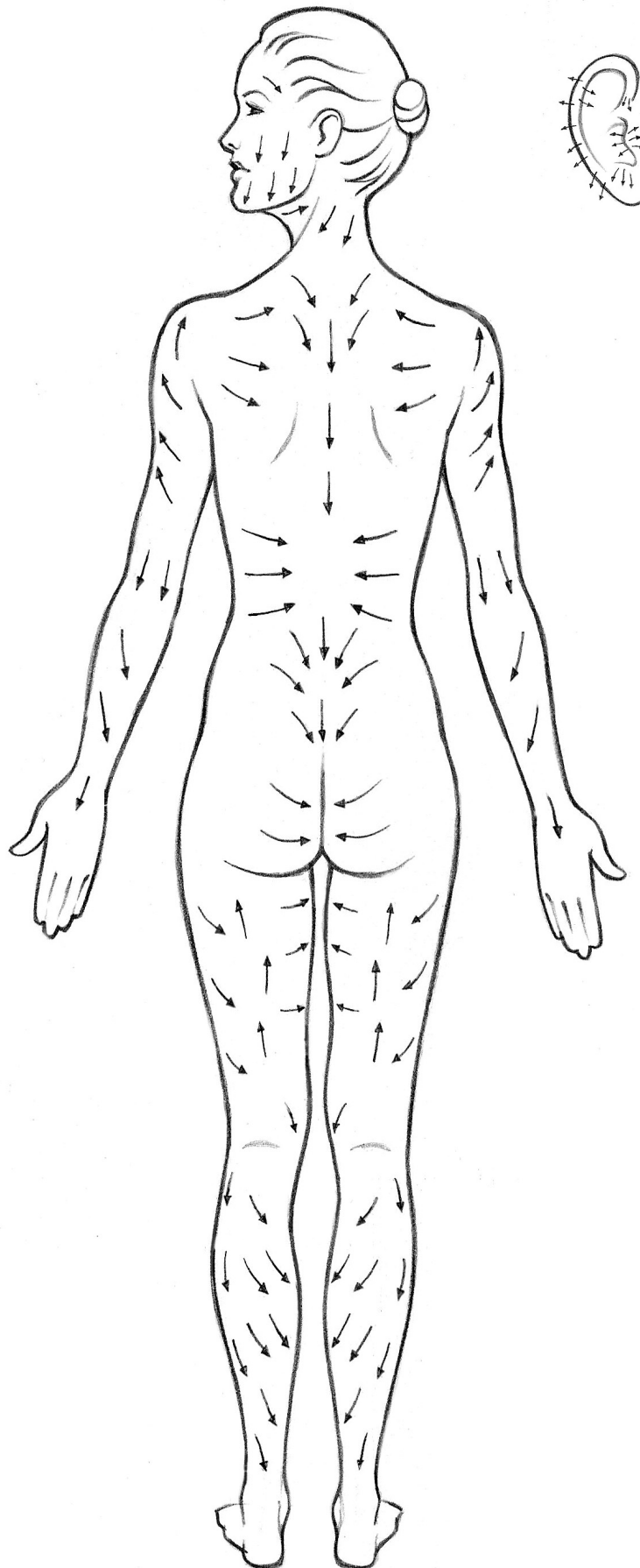
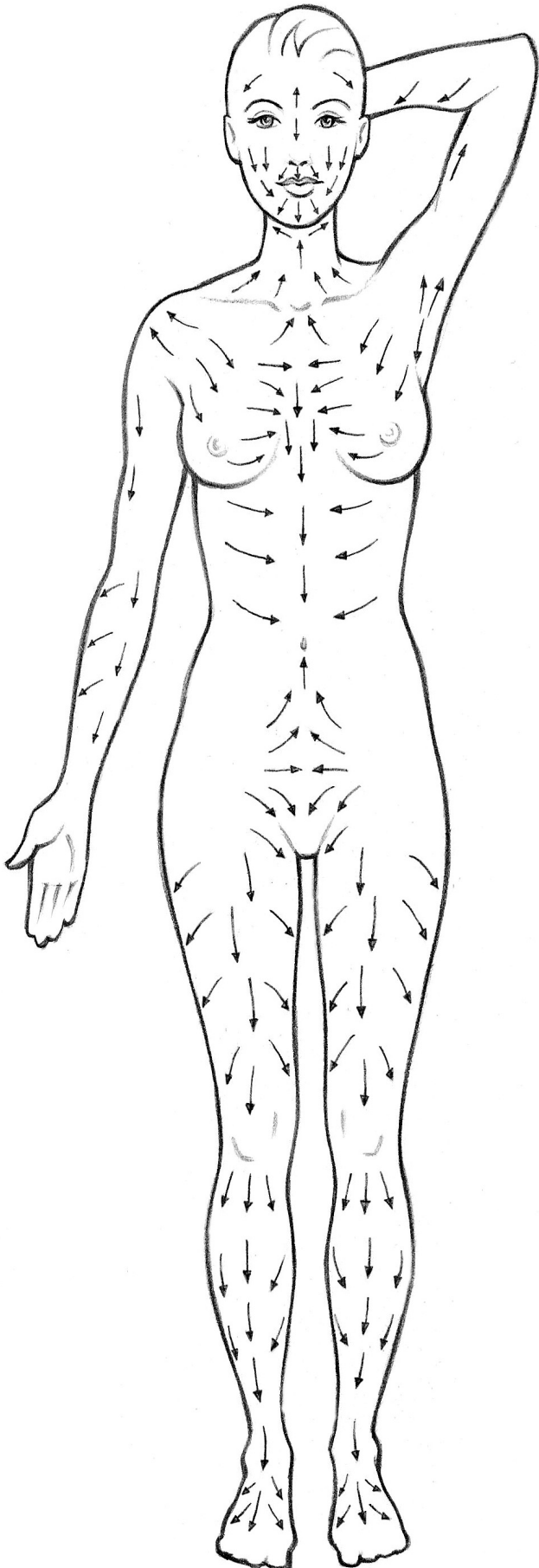
Time: _____ **Location:** _____

Temperature of Wax: _____ **Setting of Machine:** _____



Esthetics Skillbook

HAIR REMOVAL ASSESSMENT





Epidermal Cell Therapy Signature Waxing

Hair Removal Treatment Notes

Basic Esthetics Treatment Notes

Patient: _____ Date: _____ Esthetician: _____
 Esthetician Design Protocol _____

Services time ____ 60 min ____ 90 min ____ 120 min Series _____ of _____
 ____ Facial ____ Body Treatment ____ Waxing ____ Special Treatment: _____

Pre-Treatment Notes: _____

Target area _____

Hair Removal

____ Tweezing ____ Shaping ____ Hard Waxing ____ Soft Waxing

Extractions ____ No ____ Yes

Location _____		
☐ Face _____ min	☐ Eyes _____ min	
☐ Hands _____ min	☐ Neck _____ min	
☐ Back _____ min	☐ Feet _____ min	
☐ Chest _____ min	☐ Arms _____ min	
☐ Legs _____ min	☐ Ears _____ min	
☐ Nose _____ min		

____ Special Treatment: _____

Tinting

Lashes _____ Brow _____
 Color _____

Moisturizer 1 _____

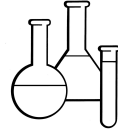
Mask 1 ☐ Swd ☐ B&H ☐ Clr Cmplx ☐ C&C
 2 _____

Post-Treatment Notes: _____

 *Signature*****Date



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